Southern California Dairy Industry
Security Trust Fund
13191 Crossroads Parkway North Suite 205,
City of Industry, CA 91746-3434
Phone No. (866) 481-5841 ● (562) 463-5033
Fax No. (562) 463-5894

For Weekly Disability Benefits Only

Instructions for Statement of Claim:

1. EMPLOYEE complete Part 1
2. Have your doctor complete Part B
3. Have your EMPLOYER complete Part 2 if loss of coverage is involved
4. Mail form and ALL BILLS to the above mailing address

Employee Name	Social Security Number	□ Male □ Female	Date of Birth
Complete Home Address			□ Married □ Widowed □ Single □ Divorced
Address City State Zip			Telephone Number
Claim is made for	Name of Claimant □ Male □ Female		

Was Disability Caused By Work? □ Yes □ No	Have you filed a claim with the workmen's Compensation carrier for this Disability? □ Yes □ No	First Date unable to work Date	Date Returned to Work

COMPLETE IF INJURY INVOLVED

Date of Accident	Time of Accident □ A.M. □ P.M.	Was claimant at work When accident happened □ Yes □ No

Place and Details of Accident:

I/We jointly certify that the above information is true and correct I/we hereby authorize all doctors, dentist, psychologist, pharmacists, hospitals or other institutions providing care, treatment consultation, drugs, or supplies to furnish the Trust Fund to release any information relevant to a determination of the applicability of or an implementation of a Coordination of Benefits provision to any Insurance carrier, service plan, union, trust Fund or employer requesting such information. A photo copy of this authorization shall be considered as effective and valid as the original.

Employee Signature Date

PART 2 – TO BE COMPLETED BY EMPLOYER WHERE APPLICABLE

1. Date of employment for the Employee_________________20____Date employee last worked ____________20___
   Date employee returned to work ___________________20_____
2. Check reason for Employee leaving work:
   Injured □ Sickness □ Quite □ Temporary Layoff □ other □ Vacation □ From ________________Through _______________
3. Employees Basic Wage at date of Disability $_______________________ Bracket Number (where applicable) _____________________
4. Employee's annual wage _______________________________
5. Employee's Drawing vacation pay_________ sick leave pay ______ _____ Termination Pay __________ if so, at what wage ____________
6. Is Disability Due to Occupational Cause? ____
7. Date __________________________Completed by ______________________________ Title ___________________________________

PART B-PHYSICIAN'S STATEMENT TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient		Date of Birth	
Diagnosis and Concurrent Conditions:		Patient Ever had Same or Similar Condition? □ No □ Yes ● if "Yes" When?	
Date Symptoms First Appeared Or Accident Happened:	Date Patient First consulted You for this condition:	Patient still under your care For this condition? □ Yes □ No	
DISABILITY	Patient was continuously total disabled (unable to work) From _______________ To ____________________	If Still Disabled, Date Patient Should Abel To Return To Work:	

ITIMIZED PROFESSIONAL SERVICES ITIMIZED	Date	Description of Surgical Or Medical Services Rendered	Charges
	I hereby approve release of information pertaining to Hospital Confinement of this patient to Benefit Programs Administration on authorization of the Insured.	**TOTAL** →	

Date	Physician's Name (Print)	Signature	Degree	Soc Sec # OR T.I.N.
Address City State Zip				Telephone Number

Signed (Insured Signature) Date